FACE FACTS

Fatality **A**ssessment & **C**ontrol **E**valuation

EMPLOYEE DIES AFTER BEING CRUSHED IN A BALER

A department store processing manager died after he was crushed in a cardboard baling machine. The safety gate was not closed prior to his pushing the "down" button to begin baling. In addition, for an unknown reason, the employee climbed into the baling chamber where he was crushed by the baler's hydraulic ram. A post-incident baler examination found that the electrical wiring had been altered to bypass the "On or Off" switch, and the gate safety switch had been short-circuited by a piece of two-inch wire. By doing so, power was always supplied to the machine and the baling machine could operate with the safety gate up. (Case Report: 04NY013)

HOW CAN THIS BE PREVENTED?

Employers should:

- Inspect all baling machines periodically to ensure safety features are working properly.
- Develop, implement, and enforce a baling machine safety program.
- Provide training and ensure management and other employees know and understand the importance of baler safety features, such as the safety gate and lockout/tagout program, and how they work.
- Ensure authorized baler operators follow standard safe operating procedures.
- Follow the manufacturer's recommended schedule for baling machine maintenance.

The Fatality Assessment and Control Evaluation (FACE) program, in cooperation with the National Institute for Occupational Safety and Health (NIOSH) is one of many workplace health and safety programs administered by the New York State Department of Health. Additional information about the FACE program can be obtained by contacting:

NYSDOH FACE, Bureau of Occupational Health, Flanigan Square, Room 230, 547 River Street, Troy, NY 12180
1-866-807-2130

FACE reports can be viewed on the New York State Department of Health website at: www.nyhealth.gov/nysdoh/face/face.htm

STATE OF NEW YORK DEPARTMENT OF HEALTH